

Health Homes in KanCare



INTRODUCTION

- The term “health home” is unique to Medicaid
- Health homes are an option which states can choose to provide within their Medicaid programs
- A health home is not a building, but is a comprehensive and intense system of care coordination that integrates and coordinates all services and supports for people with complex chronic conditions

INTRODUCTION

- Intended for people with certain chronic conditions
- Health homes can include what has been called a medical home
- Health homes do not replace acute care services, like physician visits, pharmacy, hospital care, therapies, etc.

ELIGIBILITY FOR HEALTH HOMES

Must be eligible for Medicaid, and have at least:

- Two chronic conditions;
- One chronic condition and is at risk for another chronic condition; or
- One serious and persistent mental illness

CHRONIC CONDITIONS

- Mental health conditions
 - Substance use disorder
 - Asthma
 - Diabetes
 - Heart disease
 - Being overweight, as evidenced by a body mass index over 25.
 - Section 1945(h)(2) of the ACA authorizes the Secretary to expand the list of chronic conditions
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THE PROBLEM

68% of people with mental illness have one or more co-occurring conditions

- Asthma
- Diabetes
- High blood pressure
- Heart Disease
- Obesity

People with mental illness die earlier than the general population

Substance Abuse and Mental Health Services Administration

DIABETES IN MEDICAID (FY 2011)

- Diabetes prevalence adult beneficiaries
 - 20.5% (N=37,577)
- Net payment by Kansas Medicaid
 - \$559,307,804 (36.1% of total expenses)
 - \$14,884/person

Data for fee-for-service enrollees

SIX CORE SERVICES

- Comprehensive care management
 - Care coordination
 - Health promotion
 - Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
 - Individual and family support (including authorized representative)
 - Referral to community and social support services, if relevant
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ROLE OF HIT

- To “link services”
- Quality reporting
- Provider supports/requirements
- Facilitate communication and feedback to/among providers and consumers

THREE APPROACHES TO INTEGRATED CARE

- **Facilitated referral** (develop formal and informal relationships)
- **Co-locate** physical health clinician in a behavioral health setting or vice versa
- **In-house** provision of primary care/behavioral health care together

OTHER STATES

- To receive federal funding for health homes, states must amend their State Medicaid Plans
- 12 states currently operate Medicaid health homes programs
- 2 states operate them using two State Plan amendments (SPAs)
- Remaining states have a single SPA

EARLY RESULTS FROM MISSOURI (2011 to 2012)

- Patients with at least one hospitalization decreased from 23.9% to 15.7% in primary care health homes
- Decreased from 33.7% to 24.6% in Community Mental Health Center health homes
- Reduced per 1000 admissions by 12.8%

SAMHSA-HRSA Center for Integrated Health Solutions webinar 6/27/2013

EARLY RESULTS FROM MISSOURI (2011 TO 2012)

- Reduced ER use per 1000 by 8.2%
- Net savings in ER and hospital costs - \$48.81 per health home member per month (PMPPM)
- Total Medicaid net savings \$83.26 PMPPM

SAMHSA-HRSA Center for Integrated Health Solutions webinar 6/27/2013



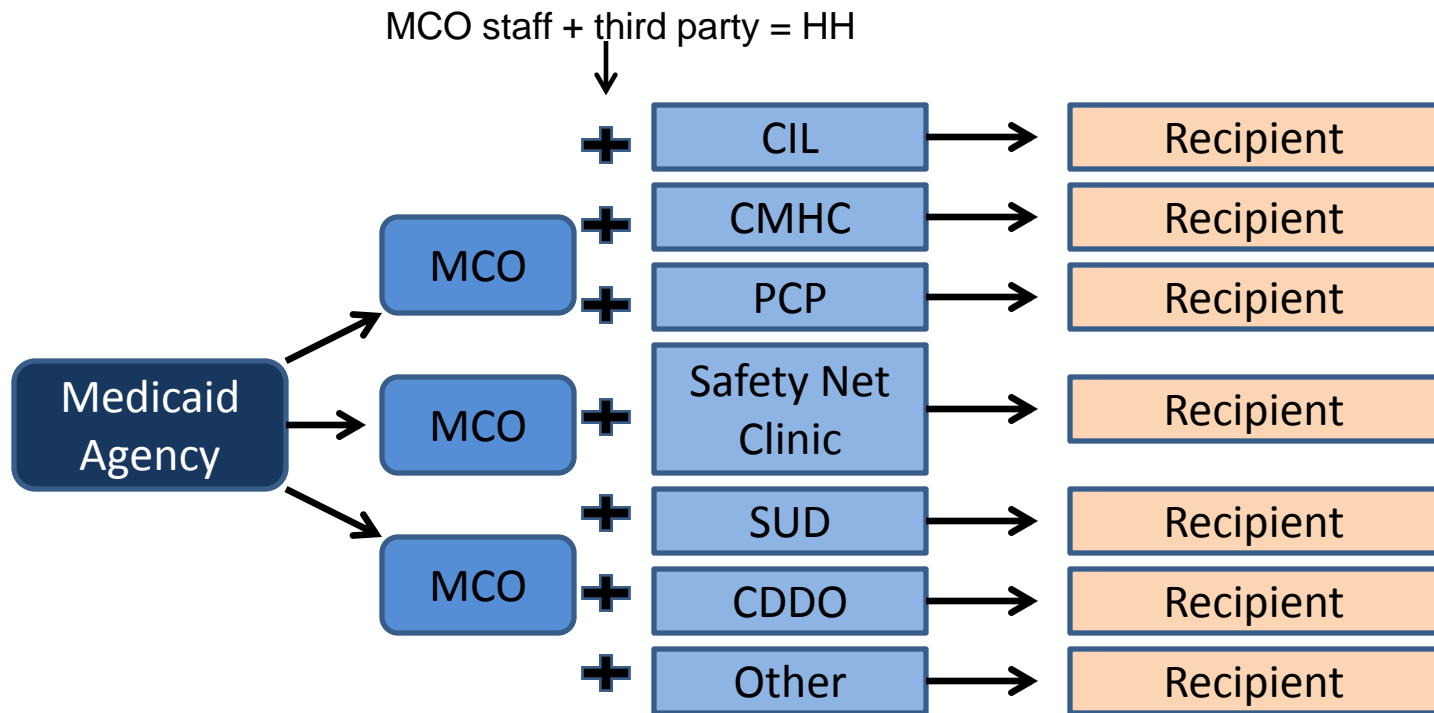
KANSAS MODEL

KS HH model allows all to be included as long as existing consumer-provider relationships are not disrupted.

We Envision A Team of Health Professionals:

May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, etc.

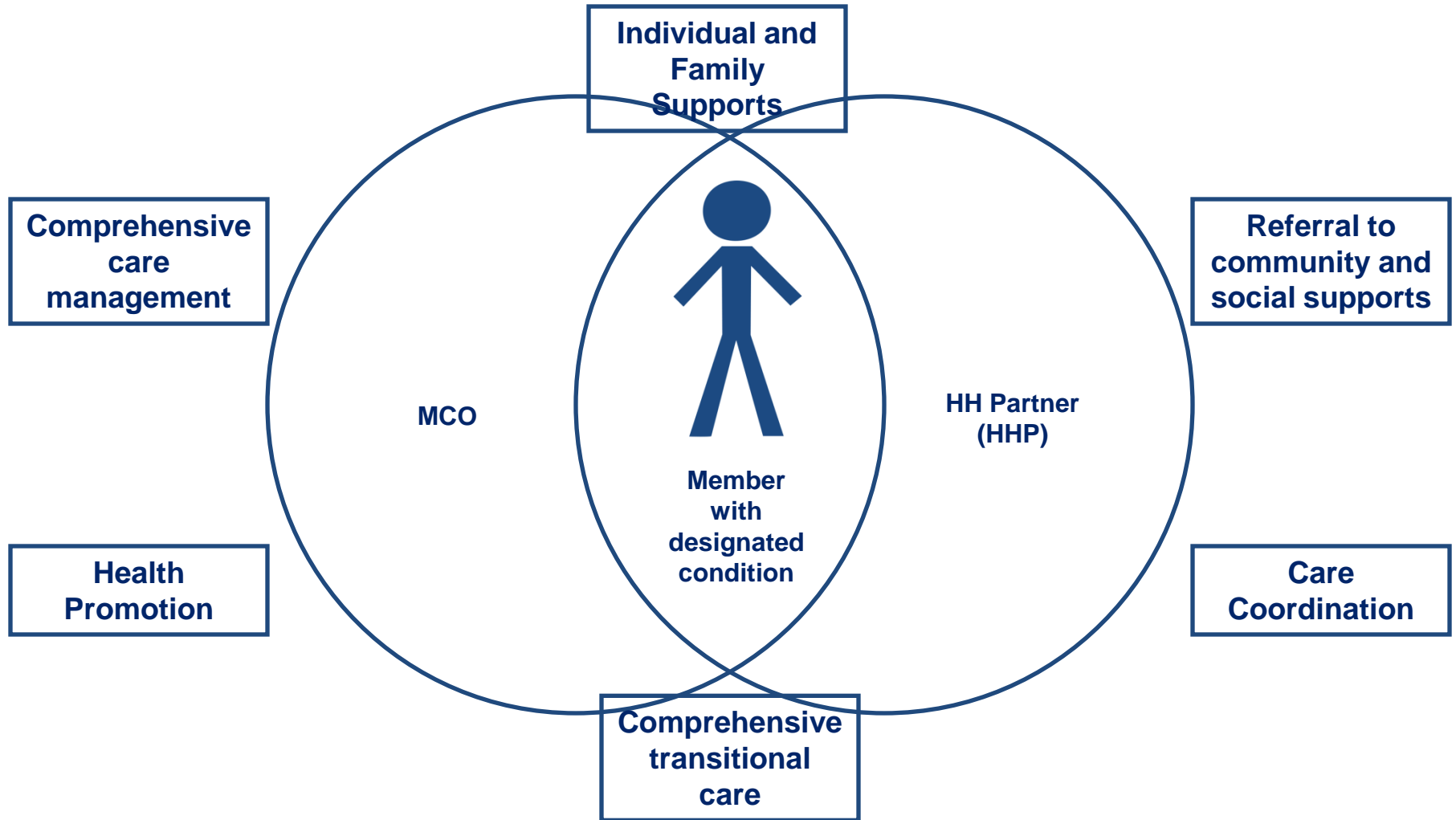
KANCARE HEALTH HOME MODEL



KANCARE HEALTH HOME MODEL

- Offers flexibility for providing health home services that will meet the unique needs of the Medicaid population
- Recipients likely have experience with, and preferences for, different types of HHPs depending upon where they live and what Medicaid population they belong to

SERVICE STRUCTURE



PARTNERING TO PROVIDE SERVICES

- Some health home services provided by the MCOs and some by the HHP
- Division of services, as well as payment between the MCO and the HHP, will be spelled out in contract between the MCO and HHP
- HHP may contract with another provider for one or more services

WORKING WITH HEALTH HOMES

- Hospitals:
 - Must refer individuals who are likely to meet the minimum eligibility requirements to a HH
 - Must communicate with HHs regarding ER and admission discharges
 - Some HHPs may want to enter into MOUs with hospitals to ensure cooperation and provision of services.

WORKING WITH HEALTH HOMES

- All Other Providers:
 - Must assist in the development and implementation of Health Action Plans
 - Must be involved in discharging individuals into HHs
 - Must participate in coordination and communication activities
 - Must provide HHs materials and information to prospective HH consumers

HEALTH HOMES PAYMENT PRINCIPLES AND PARAMETERS

- State PMPM payments to the MCOs will be adequate to ensure quality services
- MCO payments to HHPs will be adequate to ensure sustainability and quality of services
- State health home payments to the MCOs will be actuarially sound

HEALTH HOMES

IMPROVING HEALTH

Health homes ensure:

- Critical information is shared among providers and with consumer
- Consumer has tools needed to help manage his chronic condition
- Necessary screenings and tests occur timely
- Unnecessary emergency room visits and hospital stays are avoided
- Community and social supports are in place to help maintain health

KANCARE HEALTH HOMES GOALS

- Reduce utilization associated with avoidable (preventable) inpatient stays
 - Improve management of chronic conditions
 - Improve care coordination
 - Improve transitions of care between primary care providers and inpatient facilities
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TARGET POPULATIONS

- First target population is people with serious mental illness (SMI)
 - Schizophrenia
 - Bipolar and major depression
 - Child disintegrative disorder
 - Delusional disorders
 - Personality disorders
 - Psychosis not otherwise specified
 - Obsessive-compulsive disorder
 - Post-traumatic stress disorder

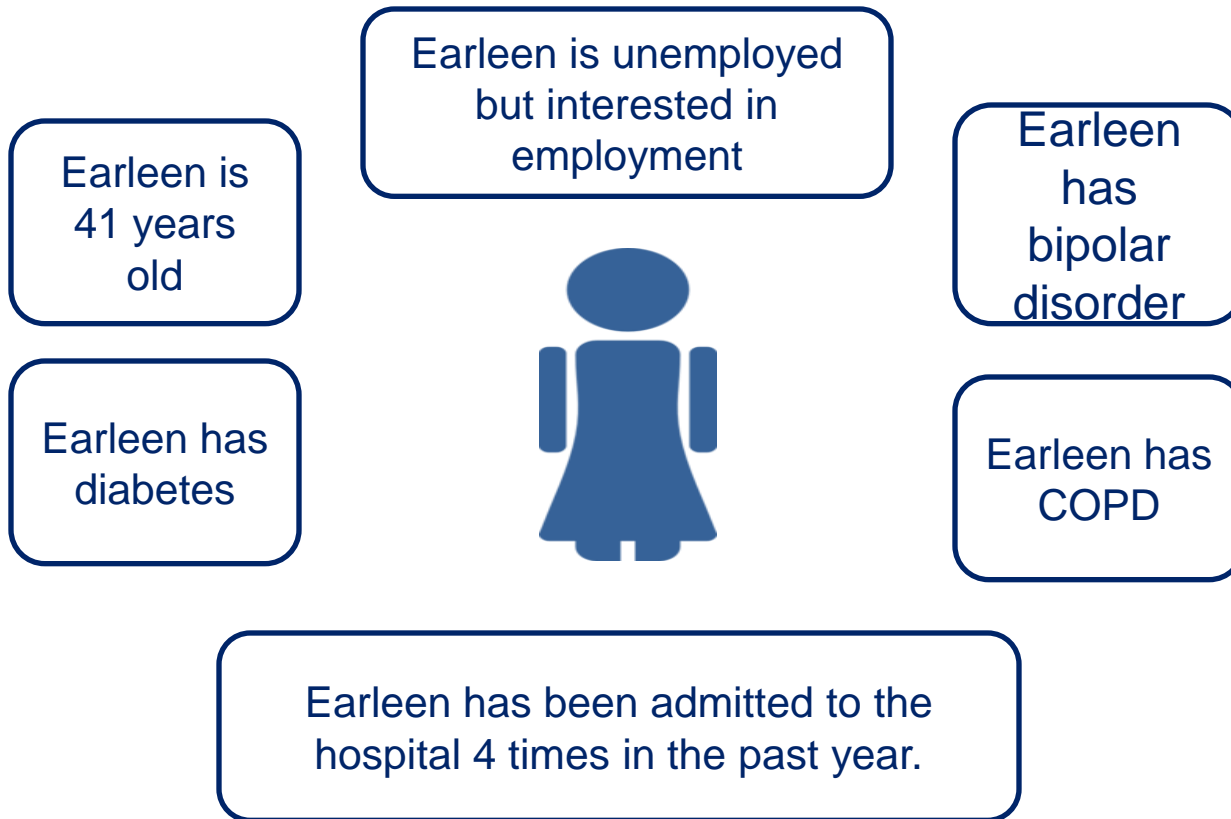
TARGET POPULATIONS

- Second target population yet to be determined, but will include people with diabetes
- Can't exclude dual eligibles or limit to a particular age group
- All HH members must be in KanCare and must select a HHP within MCO network

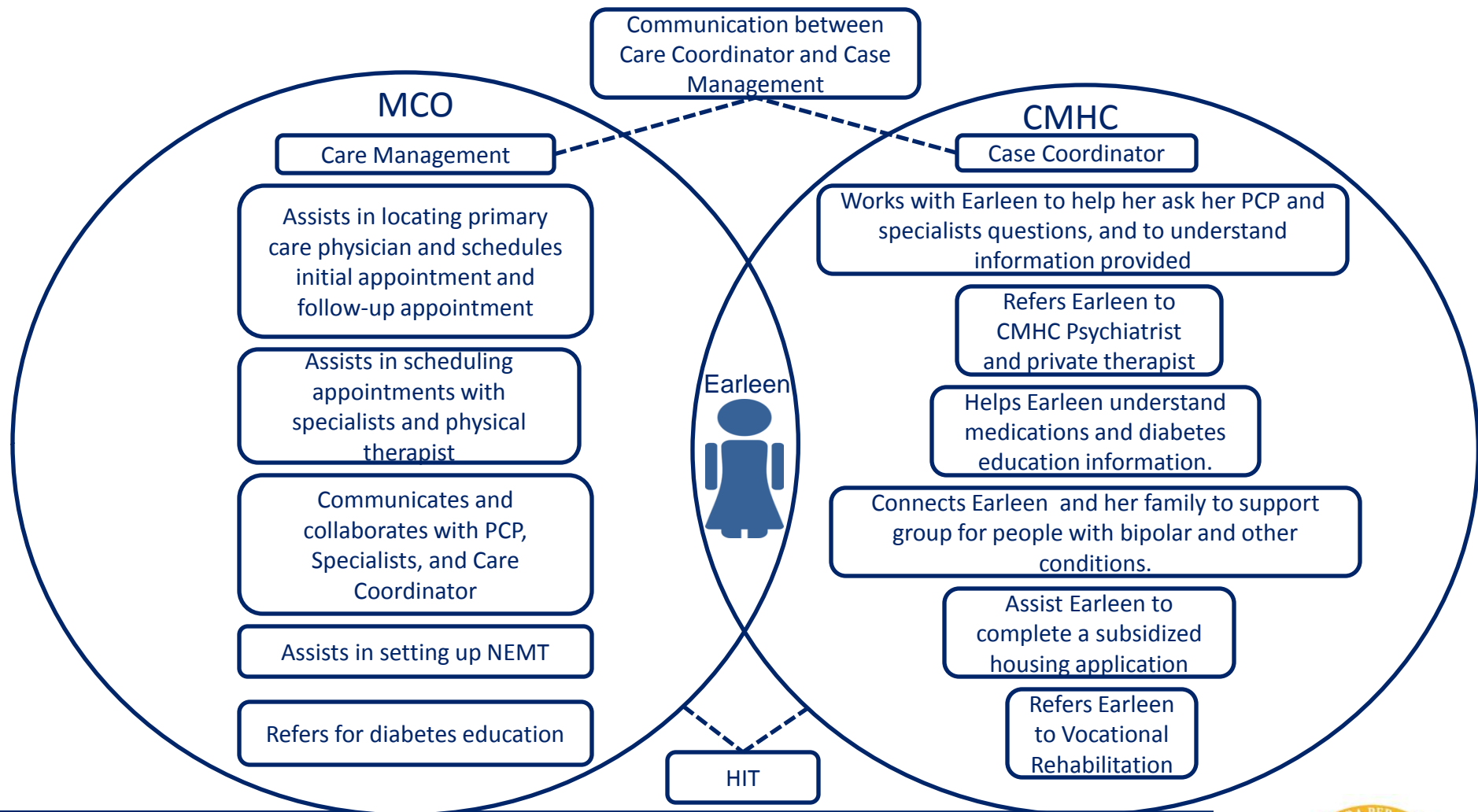
ENROLLMENT

- Passive enrollment with “opt out” feature
- Enrollee will receive a letter and have to choose to opt out
- Must have a choice of health home provider, but may be limited to certain number of times in a year
- Grievance and appeal rights

MEET EARLEEN



KANCARE Health Home: Scenario – How will KanCare help Earleen?



KANCARE Health Home: Scenario – Meet Ethel

Ethel has
arthritis

Ethel has some symptoms
that appear to be related to
dementia and appears
depressed

Ethel is 81
years old

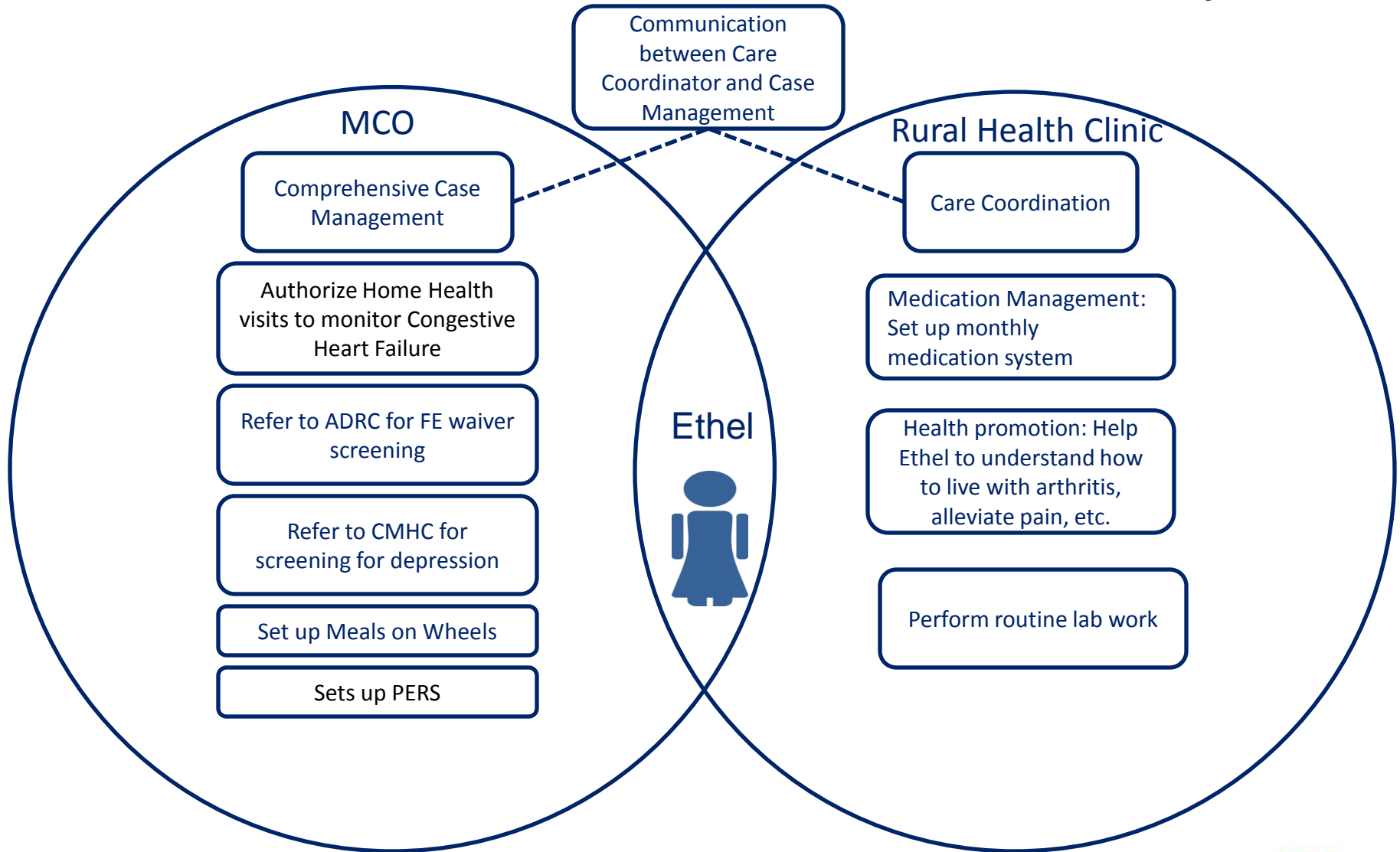
Ethel has Congestive
Heart Failure



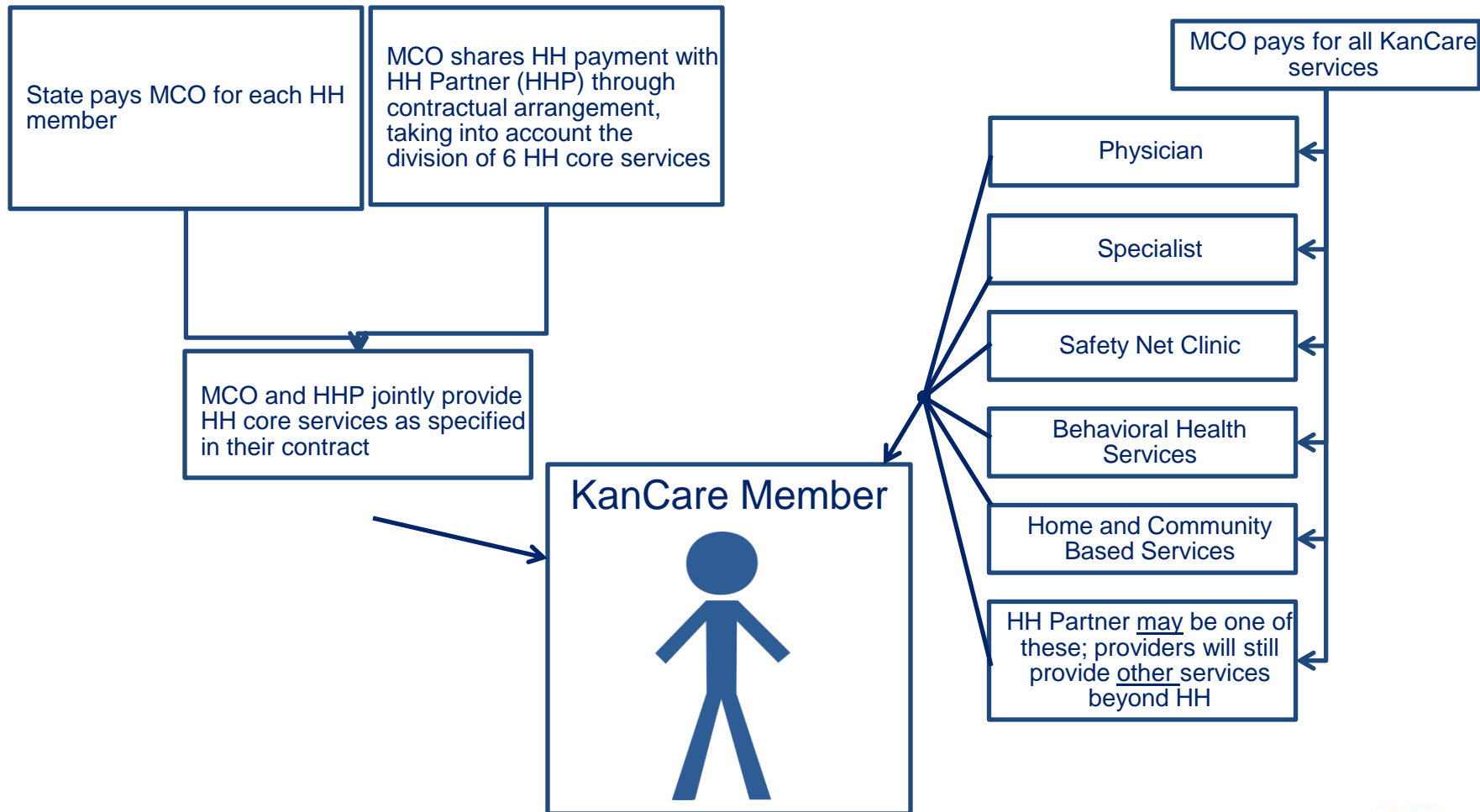
Ethel is not eating
properly

Ethel has had several falls because of
joint degeneration in her knees

KANCARE Health Home: Scenario – How will KanCare help Ethel?



PAYMENT STRUCTURE



HEALTH HOMES PROJECT STRUCTURE

- Interagency team of KDHE and KDADS staff
- Technical assistance partner – Center for Health Care Strategies (CHCS)
- Project team of state staff, university and actuary partners, with MCO representatives
- Health Homes Focus Group – 80+ stakeholders who provide advice and input

Where We Are

- Engaging stakeholders
- First SPA drafted
- Consultation with SAMHSA complete
- Monthly calls with CMS
- Working on operational issues
- Analyzing data to designate target population for second SPA
- Implement HHs for two target populations (SMI and other chronic conditions) July 1, 2014

QUESTIONS?

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